

Contra Costa County Computer Vision Care (CVC) Request

Employee Information:

Name: _____ Date: _____

Work Phone: _____ Employee #: _____

Work Email: _____ Union or Mgmt Group: _____

Eye Care Professional information (if available):

Doctor's Name: _____

Doctor's Office Number: _____

Doctor's FAX Number: _____

*As of January 2014 if the doctor's information is included on the form, the doctor will receive the authorization directly in 5-7 days (no letter of authorization will be sent to the employee).
If this is left blank, the employee will receive the letter of authorization within 10 days.*

Contra Costa County Supervisor Information:

Supervisors Name: _____ Title: _____

Work Email: _____ Work Phone: _____

This CVC request is: ☐ Approved ☐ Denied

Supervisors Signature: _____ Date: _____

Contra Costa County Benefits Use Only

Employee Social Security: _____ Date of Birth: _____

Home Mailing Address: _____

Authorized By: _____ Date: _____

VSP Group Name: Contra Costa County

Phone Number: 925-335-1746

VSP Group Number: 00103022

Fax Number: 925-335-1798

VSP Division/Class 0003/0003